immediately preceding rate period. This amount shall be detrended to the base period.

(b) For facilities without a screen as determined in clause (a) of this subparagraph, operated by a provider which does operate other facilities, an agency administrative percentage based on the current reimbursement of those other facilities shall be applied.

(c) For facilities without a screen as determined in clauses (a) and (b) of this subparagraph, operated by a provider which operates other OMRDD certified residential programs, an agency administrative percentage based on the current reimbursement of the other OMRDD certified residential programs shall be applied.

(d) For facilities without a screen as determined in clauses (a) - (c) of this subparagraph, operated by a provider which does not operate any other OMRDD certified residential programs, a regional average administrative percentage based on the current reimbursement of facilities operated by other providers shall be applied.

(e) For facilities without a screen value as determined per clause (a) of this subparagraph, the administrative screen value shall be equal to the percentages derived from clause (b),(c) or (d) of this paragraph times the reimbursable operating costs other than administration. This value shall be detrended to the base year.

(ii) Reimbursable administration costs shall be the lesser of administrative base year costs/ budget costs, or the screen value as determined in subparagraph (i) of this paragraph.

(2) Direct care screens and reimbursement.

(i) Screen. The direct care screen value shall be the direct care FTEs multiplied by the regional salary.

(a) Direct care FTEs shall be calculated utilizing the facility specific disability increment plus bed size increment. The term disability increment shall mean the process of developing facility specific direct care FTEs based upon aggregate consumer disability characteristics as described in subdivision 690.7 (g) of this Title and reported on the Developmental Disabilities Profile (DDP). The disability increment methodology will only be calculated if at least 50 percent of the DDP scores are available. If less than 50 percent of the DDP scores are

available, the direct care FTEs calculated shall be based upon bed size increment alone. The disability increment using the DDP scores is calculated as follows: 0.063 FTEs times the facility mean direct care score plus .008 FTEs times the facility mean behavior score plus 0.062 FTEs times the facility standard deviation direct care score minus 0.019 FTEs times the facility standard deviation behavior score. The direct score is computed for each consumer from the DDP adaptive and health/medical scores as follows: 7.962 plus 0.156 times the adaptive score plus 1.611 times the health/medical score. The bed size increments are as follows:

Bed size	Bed size increment
four	5.700
five	8.310
six	6.448
seven	7.123
eight	8.294
nine	9.171
ten	10.957
eleven	10.939
twelve	12.746
thirteen	9.277
fourteen	15.154
fifteen	10.507
sixteen	14.530
seventeen	16.987
eighteen	18.501
nineteen	18.751
twenty	15.115
twenty-one	20.515
twenty-two	24.873
twenty-three	19.688
twenty-four	22.935
twenty-five	24.043
twenty-six	30.361
twenty-seven	31.325
twenty-eight	32.265
twenty-nine	33.205
thirty	34.145

(b) Direct care regional salaries.

Region	
I	$26,024
II	24,627
III	21,085

Note: The above values are in base year dollars.

(ii) Reimbursable direct care costs shall be the lesser of the base year costs/budget costs or the screen values established by subparagraph (i) of this paragraph.

(3) Support personal service screens and reimbursement.

(i) Screen. The support screen value shall be the support FTEs multiplied by the regional salary.

(a) Support FTE screen values for budget-based facilities:

Bed size	Support FTE value
4	0.59
5	0.74
6	0.89
7	1.04
8	1.19
9	1.34
10	1.49
11	1.64
12	1.79
13	1.941
14	2.091
15	2.241
16	2.391
17	2.541
18	2.691
19	2.841
20	2.991
21	3.141
22	3.291
23	3.441

24	3.591
25	3.741
26	3.891
27	4.041
28	4.191
29	4.341
30	4.491

(b) Support FTE screen values for cost-based facilities are based on the base year cost report.

(c) Support regional salaries.

Region

I	$26,024
II	24,627
III	21,085

Note: The above values are in base year dollars.

(ii) Reimbursable support personal service costs shall be the lesser of the base year costs/budget costs, or the screen values established in subparagraph (i) of this paragraph.

(4) Clinical screens and reimbursement.

(i) For facilities which are not newly certified, the clinical screen shall be the value contained in the base year cost report.

(ii) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the clinical screen will be equal to the clinical costs reimbursed in the rate effective on the last day of the immediately preceding rate period.

(iii) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, the clinical screen will be based upon budgeted FTEs, reviewed and adjusted if necessary through a desk audit process, and multiplied by the base year average reimbursed clinical salary of the other facilities operated by the provider. If the provider does not operate any other facilities then a base year regional average reimbursed clinical salary will be utilized.

(iv) For facilities which are not newly certified the reimbursable clinical costs shall be the base year clinical costs. For newly certified facilities the reimbursable costs shall be the lesser of the clinical budget year costs or the screen values established in subparagraph (ii) or (iii) of this paragraph.

(5) Fringe benefit screens and reimbursement.

(i) For every new rate cycle, OMRDD shall compute a facility-specific fringe benefit percentage. This percentage shall be determined by summing the direct care, clinical and support fringe benefit costs from the base year budget or cost report and dividing this sum by the sum of direct care, clinical and support personal service costs (exclusive of contracted personal service) from the base year budget or cost report.

(ii) For newly certified facilities, that have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen shall equal the fringe benefit percentage contained in the rate effective on the last day of the immediately preceding rate period.

(iii) For newly certified facilities, that do not have a rate effective on the last day of the immediately preceding rate period, the fringe benefit percentage screen (as calculated in subparagraph (i) above) shall equal the average percentage reimbursed to existing facilities currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage screen shall equal the average reimbursed fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage screen shall equal the regional average percentage reimbursed to other facilities.

(iv) Reimbursable fringe benefit costs shall be equal to the computed fringe benefit percent established in subparagraphs (i), (ii) or (iii) of this paragraph multiplied by the reimbursable direct care, clinical and support personal service dollars, exclusive of contracted personal service.

(6) Support OTPS (other than personal service) screens and reimbursement.

(i)

Capacity	Region I	Region II	Region III
4	51,314	41,999	39,150
5	64,142	52,499	48,938
6	76,970	62,999	58,725
7	89,799	73,499	68,513
8	102,627	83,999	78,300

9	115,456	94,498	88,088
10	128,284	104,998	97,875
11	141,112	115,498	107,663
12	153,941	125,998	117,450
13	166,769	136,498	127,238
14	179,598	146,998	137,025
15	192,426	157,497	146,813
16	205,254	167,997	156,600
17	218,083	178,497	166,388
18	230,911	188,997	176,175
19	243,740	199,497	185,963
20	256,568	209,997	195,570
21	269,396	220,496	205,538
22	282,225	230,996	215,325
23	295,053	241,496	225,113
24	307,882	251,996	234,900
25	320,710	262,496	244,688
26	333,538	272,996	254,475
27	346,367	283,495	264,263
28	359,195	293,995	274,050
29	372,024	304,495	283,838
30	384,852	314,995	293,625

Note: The above values are in base year dollars.

(ii) Reimbursable support OTPS costs shall be the lesser of the base year costs / budget costs, or the screen values established in subparagraph (i) of this paragraph.

(7) Utility costs will not be included within the support OTPS screen. The reimbursable utility costs shall be the base year costs or budget costs.

(8) OMRDD shall include in reimbursable costs a regional FTE add-on calculated by multiplying FTEs established per subparagraph (2)(i)(a) of this paragraph by the following dollar amounts:

Region One	$624.00
Region Two	$623.35
Region Three	$556.87

Note: The above values are in base year dollars.

(e) Cost Category Screens and reimbursement for over thirty bed facilities. In order to determine the reimbursable operating costs to be included in the rate calculation, the following screens (i.e., the maximum amount that will be allowed for a specific item or group of items) will be used.

(1) Direct care, mid-level supervision, and clinical personal service cost category screens:

(i) For every new rate cycle, OMRDD shall develop values by applying a maximum statewide salary amount to a facility's applicable consumer specific staffing standards. Refer to paragraphs (5)-(8) of this subdivision.

(ii) These standards shall reflect the severity of disabilities of the population residing at the facility as determined by the procedures outlined in paragraphs (5)-(7) of this subdivision; the number of beds in the facility; whether or not a facility provides on site day program services; and the persons the facility provides services to (i.e., adults, children or both).

(iii) For any facility which elected to participate in the salary enhancement plan as evidenced by adoption of a resolution of its governing body, effective on the later of October 1, 1987, or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted to reflect the obligation to pay salary levels established by adoption of the resolution referred to in this subclause. In absence of such an election, the standard shall be determined by the facility's actual salary amount based upon the budget or cost report used to establish the rate being adjusted or calculated.

(2) Administrative and support cost category screens:

(i) OMRDD shall develop values for every new rate cycle by application of a statewide maximum allowable cost.

(ii) The personal service costs shall be determined by applying a maximum statewide salary amount to the allowable staffing level contained in this subdivision.

(iii) For any facility which elected to participate in the salary enhancement plan as evidenced by adoption of a resolution of its governing body, effective on the later of October 1, 1987, or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted to reflect the obligation to pay salary levels established by adoption of the resolution referred to in this subclause. In the absence of such an election, the standard shall be

determined by the facility's actual salary amount based upon the budget or cost report used to establish the rate being adjusted or calculated.

(3) Fringe benefit cost category screens:

(i) For every new rate cycle, OMRDD shall compute a facility- specific fringe benefit percentage. This percentage shall be determined by computing the total fringe benefit cost from the base year budget or cost report and dividing this total by the total personal service cost (exclusive of contracted personal service) from the base year budget or cost report. For every rate cycle after April 1, 1984, this percentage shall be the lower of the previous rate cycle's cost-based fringe benefit percentage plus one percent or a new percentage computed in accordance with the immediately preceding sentence. If a facility's previous rate is based upon a budget, it is not subject to the aforementioned one-percent fringe benefit limitation.

(ii) To determine the fringe benefit component of the rate, the facility- specific fringe benefit percentage shall be multiplied by the total reimbursable personal service dollars exclusive of contracted personal services.

(iii) For newly certified facilities, the fringe benefit percentage allowed shall not exceed the average allowed for existing facilities (regardless of size) currently operated by the provider. If there are no existing facilities, then the fringe benefit percentage allowed shall not exceed the fringe benefit percentage of any other programs operated by the provider. If the provider does not operate any other programs, then the fringe benefit percentage allowed shall not exceed the regional average for other facilities.

(iv) Any increase in the fringe benefit percentage due to Federal or State laws, rules or regulations shall not be subject to the percent increase limitation described in subparagraph (i) of this paragraph.

(v) If a newly certified facility whose base period rate was determined from total reimbursable budget costs, submits a cost report for the subsequent period in accordance with subpart 635-4 of this Title, a new fringe benefit percentage shall be computed by dividing these costs by the total personal service costs (exclusive of contracted services) as submitted in the new cost report. This percentage shall be subject to the limitations of subparagraphs (i) and (ii) of this paragraph.

(4) Other than Personal Service (OTPS) and Overhead shall be combined into one cost category screen.

(i) The Other than Personal Service cost category screen will be based on a per bed amount effective at the beginning of each new rate cycle (see paragraph (8) of this subdivision.)

(ii) The Overhead cost category screen will be a percentage of reimbursable personal service and fringe benefits (see paragraph (8) of this subdivision). This screen will be compared to reported cost or budget costs (agency administration, personal service, OTPS, fringe benefits and capital costs) to determine reimbursable costs.

(iii) Costs associated with transportation to and from physician, dentist and other clinical services shall be included in the Other than Personal Service screen and subject to the limitations contained therein.

(5) Over thirty bed facility staffing standards, algorithm and screens. FTE factors to determine staff allocations for consumers with differing day programs, who reside in over thirty bed facilities.

Current Willow-brook ratios	*Ratios with offsets for adults with outside day program*	*Ratios with offsets for children with outside day program*	*On site day program consumer requiring 1:1*	*31-bed facility children on-site day program*
Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE	Direct Care 1:4 0.8889 FTE 1:6 0.6399 FTE 1:16 0.3285 FTE	Direct Care 1:4 0.9442 FTE	Direct Care 3.5417 FTE	Direct Care 1:4 0.9917
Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1599 FTE	Mid-level supervision 0.1692 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE
General clinical 0.3333 FTE	General clinical 0.2934 FTE	General clinical 0.3147 FTE	General clinical See below	General clinical 0.4878 FTE

60+ bed facility children on-site day program	*100+ bed facility children on-site day program*	*31-bed facility adults on-site day program*	*60-bed facility adults on-site day program*	*100+ bed facility adults on-site day program*
Direct Care 1:4 0.9917 FTE	Direct Care 1:4 0.9917 FTE	Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE	Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE	Direct Care 1:4 0.9917 FTE 1:6 0.7083 FTE 1:16 0.3541 FTE
Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE	Mid-level supervision 0.1771 FTE
General clinical 0.4350 FTE	General clinical 0.3883 FTE	General clinical 0.4046 FTE	General clinical 0.3651 FTE	General clinical 0.3518 FTE

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(6) For the purposes of developing an economy of scale, the following FTE offsets shall be applied against the clinical ratios listed in paragraph (5) of this subdivision:

(i) For children, bed sizes 32-59, a straight deduction of 0.00182 will be computed per 1-bed increase from the 0.4878 at 31 beds.

(ii) For children, bed sizes 61-99, a straight deduction of 0.00119 will be computed per 1-bed increase from the 0.4350 at 60 beds.

(iii) For adults, bed sizes 32-59, a straight deduction of 0.00136 will be computed per 1-bed increase from 0.4046 at 31 beds.

(iv) For adults, bed sizes 61-99, a straight deduction of 0.00034 will be computed per 1-bed increase from 0.3651 at 60 beds.

(7) An assessment of consumer level of disability for the purposes of designating direct care staffing levels, as listed in paragraph (5) of this subdivision, shall be completed utilizing the following criteria.

Direct Care Shift	Ratio	Factor	Description
Day or Evening	1:4	0.25000	1) All children age 21 and under 2) All nonambulatory consumers nonambulatory or wheelchair only) 3) All multiply handicapped consumers (blind or deaf or tube- fed) 4) All nonself-preserving consumers
	1:16	0.06250	All consumers over age 22 who: 1) walk freely 2) have a mental level moderate or above 3) are toilet-trained 4) do not need help eating or dressing 5) have no serious behavior problems 6) do not have any mild behavior problems in the following categories: a) assaults others b) self-abusive c) destroys property d) runs away

			7) have some speech and comprehension
	1:6	0.16666	All others not in above categories
Night	1:12	0.08333	All consumers

(8) Cost center screens for over thirty bed facilities.

(i) From July 1 to June 30, the cost center screens shall be:

(a) Salaries.

Cost area	
Administration and support	$21,751
Direct care and mid-level supervision	20,814
Clinical	34,824

(b) Other cost center screens.

Cost area	
OTPS/bed	$ 9,190
Overhead	7.29%
Administration and support FTE	0.6284/bed

(ii) From January 1 to December 31 the cost center screens shall be:

(a) Salaries.

Cost area	
Administration and support	$19,413
Direct care and mid-level supervision	19,956
Clinical	31,931

(b) Other cost center screens.

Cost area	
OTPS/bed	$ 9,180
Overhead	6.76%
Administration and support FTE	0.56/bed

(vi) April 1 to March 31 the cost center screens shall be:

(a) Salaries

Administration and Support	$21,560
Direct Care and Mid-level Supervision	20,643
Clinical	34,495

(b) Other Cost Center Screens

Cost Area	
OTPS/Bed	$9,121
Overhead	6.34%
Administration and Support FTE	.6288 FTE/Bed

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(f) Allowable costs. To be considered allowable, costs must be properly chargeable to necessary consumer care rendered in accordance with the requirements of this Part.

(1) Allowable costs (general).

(i) Except where specific rules concerning allowability of costs are stated herein, the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, shall be used to determine the allowability of costs. HIM-15 is published by the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) and is available from:

Health Care Financing Administration
Division of Publications Management – SLL-12-15
7500 Security Boulevard
Baltimore, MD 21207

It may be reviewed in person during regular business hours at the NYS Department of State, 41 State Street, Albany, NY 12207; or, by appointment, at the NYS Office of Mental Retardation and Developmental Disabilities, Division of Revenue Management, 44 Holland Avenue, Albany, NY 12229-0001.

(ii) Where specific rules stated herein or in HIM-15 are silent concerning the allowability of costs, the commissioner shall determine allowability of costs based on reasonableness and relationship to consumer care and generally accepted accounting principles.

(iii) Expenses or portions of expenses reported by a facility that are not reasonably related to the efficient and economical provision of care in accordance with the requirements of this Part, because of either the nature or amount of the item, shall be not allowed.

(iv) Costs which are not properly related to consumer care or treatment, and which principally afford diversion, entertainment or amusement to owners, operators or employees of the facility, shall not be allowed.

(v) The OMRDD shall reduce a facility's base year costs / budget costs by the costs of such services and activities that are not chargeable to the care of the consumers in accordance with this subdivision.

(a) In the event that the commissioner determines that it is not practical to establish the costs of such services and activities, the income derived therefrom shall be substituted as the basis for reductions of the facility's reported or estimated costs.

(b) Examples of sources of such income include, but are not limited to:

(1) supplies and drugs sold by the facility for use by nonresidents;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) employees' rental of living quarters;

(5) cafeterias;

(6) meals provided to staff or a consumer's guests for which there is a charge;

(7) operating parking facilities for community convenience; and

(8) lease of office and other space by concessionaires providing services not related to intermediate care facility services.

(vi) Costs for any interest expense related to funding expenses in excess of an approved rate, or penalty imposed by governmental agencies or courts and the costs of insurance policies obtained solely to insure against such penalty, shall not be allowed. OMRDD will not pay interest on the final dollar settlement resulting from the retrospective impact of the rate appeals.

(vii) Costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.

(viii) Costs of related organizations, other than costs incurred pursuant to a lease, rent or purchase of real property, may be an allowable cost subject to the following:

(a) A related organization means any entity of which the facility is in control or by which the facility is controlled including the organizations and persons listed in clauses (3)(iii)(c)-(f) of this subdivision, either directly or indirectly, or where an association of common interest exists in an entity which supplies goods and/or services to the facility.

(b) The costs of goods and/or services furnished to a facility, within the course of normal business operations, by a related organization, are allowable at the cost to the related organization, or the market price of comparable goods and/or services available in the facility's region, whichever is lower.

(ix) Restricted funds are funds expended by the facility, which include grants, gifts, and income from endowments, whether cash or otherwise, which must be used only for a specific purpose as designated by the donor or grant instrument. Except as provided for in clauses (3)(iv)(d) and (e) of this subdivision, restricted funds are to be deducted from the designated costs when determining allowable costs. The commissioner may waive the provisions of this subparagraph at his discretion only in those instances where the provider makes a reasonable showing that the imposition of the requirements of this subparagraph would cause undue financial harm to the existence of the facility.

(x) Only that portion of the dues paid to any professional association which has been demonstrated to be attributable to expenditures other than for lobbying or political contributions shall be allowed.

(xi) A monetary value assigned to services provided by a religious order for services rendered to an owner and operator of a facility shall be considered allowable subject to review by OMRDD for reasonableness.

(xii) Funded depreciation.

(a) Applicability. This subparagraph shall apply to all facilities except those governed by clause (3)(iv)(d) or (e) of this subdivision and those for which the provider is receiving or has a commitment to receive HUD funding. This section shall apply to facilities which were governed by clause (3)(iv)(d) or (e), but which are no longer governed by either such section because the provider has repaid the entire principal owed on the real property of the facility.

(b) Effective April 1, 1986, for any rate period during which the reimbursement attributable to depreciation on a facility's real property, excluding equipment, exceeds the provider's principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such difference in an interest-bearing checking account or other secure investment. If the provider operates more than one facility governed by this paragraph, the provider may maintain one funded depreciation account for two or more facilities. The provider shall not commingle such funded depreciation accounts with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider's equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the facility.

(c) OMRDD will not reimburse interest expense incurred to meet funded depreciation, pursuant to this subparagraph and clauses (3)(iv)(d) and (e) of this subdivision.

(2) Allowable costs (operating).

(i) Interest on working capital indebtedness in accordance with standards listed in subparagraph (3)(vii) of this subdivision and subject to the limitations of paragraphs (d)(1) or (e)(4) of this section will be considered allowable. In the event that a loan is not in accordance with the standards listed above, then the approval of the commissioner is required.

(ii) Effective April 16, 1992, costs incurred as a result of the provider of services assessment charged pursuant to section 43.04 of the Mental Hygiene Law in the amount of 2.4 percent of the 3 percent assessment charged on cash receipts shall be included in the rate.

(iii) Effective April 4, 1996, costs in excess of 0.6 percent incurred as a result of the provider of services assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be included in the rate. Effective April 1, 1999, costs in excess of 0.3 percent incurred as a result of the provider of services assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be included in the rate. Effective April 1, 2000, the assessment charged on cash receipts pursuant to section 43.04 of the Mental Hygiene Law shall be a reimbursable expense.

(iv) Allowable operating costs shall also include, but not be limited to, personal service, fringe benefits, OTPS, utility, administration costs, as well as day treatment, day services, and transportation costs, and regional FTE add-ons.

(v) Liability for compensated absences determined and accrued in accordance with generally accepted accounting principles for governments as promulgated by the Governmental Accounting Standards Board shall be considered an allowable cost.

(3) Allowable costs (capital).

(i) Start-up costs are those costs which are incurred from the period the provider receives approval pursuant to 14 NYCRR Part 620 for a facility to become an intermediate care facility to the date the first consumer is admitted. However, costs incurred during the period from the first admission to the effective date of the initial provider agreement shall not be considered as start-up costs.

(a) OMRDD may, at the discretion of the commissioner, reimburse a provider for all allowable start-up costs incurred in the preparation of the provider during that six-month period prior to the date of the first consumer admission. A provider may apply to the commissioner for an extension of the six-month reimbursable start-up period, provided that the provider can demonstrate why such an extension is necessary. However, under no circumstances shall a facility be allowed reimbursement of start-up costs for any period of time exceeding 18 months prior to the date of the first consumer admission.

(b) Allowable start-up costs may include, but not be limited to:

(1) personal service expenses;

(2) utility expenses;

(3) taxes;

(4) insurance expenses;

(5) employee training expenses;

(6) housekeeping expenses;